PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Prevention of recurrence of Clostridioides difficile infection (CDI) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____
2. What is the patient's age?
   - Less than 18 years (If checked, no further questions) ☐
   - 18 years of age or older (If checked, go to 3) ☐
3. Is the requested drug being used for the treatment of Clostridioides difficile infection (CDI)? **Y** ☐ **N** ☐
4. Has the patient had three or more episodes of CDI within the past 12 months (including the most recent episode)? ACTION REQUIRED: If Yes, attach supporting medical records, chart notes and/or lab test results documenting the episodes of recurrent CDI within the past 12 months are required. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
5. Did the patient have a recent episode of recurrent CDI with at least three unformed stools per day for two consecutive days? **Y** ☐ **N** ☐
6. Did the patient have a stool test confirming the presence of C. difficile toxin or toxigenic C. difficile during the patient's recent episode of recurrent CDI? ACTION REQUIRED: If Yes, attach supporting medical records, chart notes and/or lab test results of stool test confirming the presence of C. difficile toxin or toxigenic C. difficile. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
7. Did the patient have a recent episode of recurrent CDI with an adequate clinical response (e.g., resolution of symptoms) following standard of care antibiotic therapy (e.g., vancomycin, fidaxomicin)? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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